Childhood Blood Lead Level Report

Confidential Medical Record

Send to:	**From:**
West Virginia Department of Health and Human Resources Bureau for Public Health Office of Maternal, Child and Family Health Division of Research, Evaluation and Planning **Childhood Lead Poisoning Prevention Program** Phone: 1-800-642-8522 Fax: 304-558-3510	Medical Facility: Requesting Physician: City/State/Zip: Phone Number: Fax Number:

Child Information		
Last Name:	First Name:	M.I.:
Date of Birth:	Gender: ☐ Male ☐ Female	
Guardian Name:	Medicaid ☐ CHIPS ☐	
Physical Address:		Apartment #:
City:	State: WV	Zip:
Mailing Address:		Apartment #:
City:	State: WV	Zip:
Phone Number:		
Ethnicity: (*check one*) ☐ Hispanic ☐ Non-Hispanic ☐ Unknown		
Child Race: (*check one*) ☐ White ☐ Black ☐ Asian or Pacific Islander ☐ Native American or Alaskan Native ☐ Multi-Racial ☐ Other		

Blood Lead Level Information	
Blood Lead Test Level: _____ micrograms per deciliter (µg/dL)	Blood Draw Date: ___/___/___
Type of Blood Sample: (*check one*) ☐ Initial ☐ Repeat ☐ Unknown	Source of Sample *(check one)* ☐ Capillary ☐ Venous ☐ Unknown
Testing Laboratory: _____ Laboratory Phone and Contact Person: _____ _____	**If Using LeadCare II System, Place Label Here**

Please report all elevated blood lead levels (≥10µg/dL) to the Bureau of Public Health within 7 days of testing. The West Virginia Childhood Lead Poisoning and Prevention Program provide care coordination for all children 0 – 72 months with a blood lead level of ≥5 µg/dL.